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Editorial comment: Specialist services in the community: a qualitative study of consultants holding novel types of employment contracts in England

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OVERVIEW

Editorial comment on 'Specialist services in the community: a qualitative study of consultants holding novel types of employment contracts in England' by Emma Pitchforth and Martin Roland

Recent UK health policy statements have placed increased emphasis upon care delivered closer to home.[1] In this context, an increasing number of service and contract specifications for specialist physicians to work in the community have been established.

The movement of secondary and tertiary level expertise into the community has, for geriatricians at least, long been a source of considerable angst. Much of this soul searching has focused around the assertion that translocating geriatricians from hospital-based clinics and wards is of unproven benefit and comes with some opportunity cost. Geriatricians employed in the care home sector, or in doing domiciliary visits, will not be available to support orthogeriatric ward rounds or ward-based rehabilitation, each of which has more evidence for improving clinical outcomes than community geriatrics. Fourteen years after fractious and, at times, undignified debate about this exploded onto the pages of the BMJ,[2,3] we are no closer to understanding the comparable efficacy, or cost effectiveness, of what a geriatrician can deliver in the community, versus what they can do if employed elsewhere. This is, in part at least, a consequence of the fact that understanding the clinical impact of a single specialist physician as a contributor to complex health and social care systems confounds traditional evaluative methodologies.

Other specialties that have moved out of hospitals have manifested lesser degrees of uncertainty about the positive effect of the transition. Respiratory medicine, for example, have recognised intuitive gains from seeing patients with chronic obstructive pulmonary disease (COPD) earlier in their illness trajectory and have accepted this as part of the narrative of the efficacious intervention of providing integrated care for this particular long-term condition.[4]

It is possible that these differing narratives represent differing psychologies, or psychopathologies, within individual specialties. They may also reflect the divergent nature of the community interventions. Community-based integrated respiratory clinics are quite similar to COPD clinics as delivered in a hospital setting.[5] A geriatrician driving from house to house in his or her car providing specialist opinions is, on the face of it, more different from the role played by these specialists in hospital. The situation is also potentially less complicated for patients with single long-term conditions than it is for older patients with frailty, many of whom have multiple long-term conditions.[6]

However, the respiratory approach represents a logical way forward. This is to accept that the community-based specialty physician is not an intervention in and of themself but is, rather, an enabler for the broader intervention of integrated care. Comprehensive geriatric assessment (CGA), which describes multi-domain, multi-professional, case-managed iterative care, is a model of integrated care which has been shown to improve outcomes for older patients with frailty when delivered in the community.[7] Geriatricians in hospital realise their effect by working in teams that deliver CGA. Community-based geriatricians will do the same. Perhaps the setting in which care is delivered is less important than the fact the intervention, for geriatricians, truly represents CGA and, for respiratory physicians, truly represents integrated care.

The question then becomes less about how we establish efficacy of community-based specialist physicians and more about the manner in which they interface with other professionals, patients and their families in the community to support evidence-based models of care. Against this background, the early efforts already undertaken to develop and implement these roles represent an important bed of experiential learning. Insights generated from such experiential learning, from a qualitative interview study conducted with community-based geriatricians, respiratory and palliative care physicians, are presented in this issue of the journal.[8] A number of these insights are potentially quite important and focus around a paucity of role specification, a typology of the work undertaken and the fact that many colleagues undertake these posts without much specific training.

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A clear challenge that all respondents recognised was the need to negotiate clear roles and responsibilities within permissive contract and service specifications. This came with both opportunities and threats. Opportunities existed to develop the sort of service that incumbents felt could make a real difference to care of their core constituency; however this was balanced by feelings of isolation or redundancy. Potential solutions to these difficulties emerge when one considers the type of work undertaken and a description of the education required to enable incumbents to fulfill the roles described.

Considering the type of work undertaken, the paper very clearly does not describe substitution of specialist community physicians for general practitioners (GPs). Rather, interview respondents recognised a role in providing specialist support in closer relationship with GPs, which made their expertise more readily accessible than if they had remained in a traditional hospital-based clinic. A bridging role into secondary care was recognised and, although several respondents seemed to identify difficulties in maintaining this, it was nevertheless a relatively unique function of the community specialist physician.

For several respondents the community role involved them taking what the authors call a 'population perspective'. This might, alternatively, be defined as engaging proactively with those who commission, design and manage the delivery of healthcare. It would be rare for grass-roots hospital consultants to engage with these levels of NHS administration on a routine basis and this role as topic expert to support higher level decision making is another relatively unique aspect of the community specialist physician role.

An important insight from the study was the extent to which the incumbents felt poorly prepared for their current jobs. For new consultants this was through a lack of formal coverage in higher specialty training. Established consultants recognised a lack of continuing professional development (CPD) opportunities to make themselves ready for their new roles when moving from traditional hospital posts. This should serve as a call to arms for deaneries, training programme directors and the specialty organisations, including the British Thoracic and Geriatrics Societies and the Association of Palliative Medicine, to develop such opportunities.

The recent community focus of the NHS *Five-year forward view*[1] makes it likely that community-based specialist physician posts will continue to propagate. Each of these opportunities will, of course, come with opportunity costs. In the context of the current direction of travel, however, such debate seems somewhat sterile. Focus should instead be on making sure that the posts developed follow rational and coherent lines to make the most of specialist physicians' unique skill sets in order to augment existing models of care. The observations presented in this issue represent an important contribution. ■

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